

Anna J. Thomas, MPH
Public Health Director



Philip J. Alexakos, MPH, REHS
Chief Operations Officer

Jaime L. Hoebeke, MPH, MCHES
Chief Strategy Officer

CITY OF MANCHESTER
Health Department
STUDENT HEALTH HISTORY

Full Name: _____ **DOB:** _____ **Gender:** _____

<p>Pregnancy & Birth</p> <p>-Did the child or mother have any health problems during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>-Were there any complications during birth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>-If yes, what were the complications?</p> <p><input type="checkbox"/> Prematurity... if checked, birth weight _____</p> <p><input type="checkbox"/> Anoxia (<i>baby did not get enough oxygen</i>)</p> <p><input type="checkbox"/> Eclampsia / pre-eclampsia (<i>mother had high BP</i>)</p> <p><input type="checkbox"/> Respiratory distress syndrome</p> <p><input type="checkbox"/> Meconium (<i>baby's fecal material is excreted at birth</i>)</p>	<p>Ears, Eyes, Nose & Throat</p> <p><i>Please check each box that applies to your child</i></p> <p><input type="checkbox"/> Vision problems</p> <p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Frequent ear infections</p> <p><input type="checkbox"/> Tympanostomy (ear) tubes</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Frequent strep throat infections</p> <p><input type="checkbox"/> Frequent nosebleeds</p>
<p>Infancy</p> <p>-Was your child ill during the first three months of life? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Skin</p> <p><input type="checkbox"/> Problems with rashes</p> <p><input type="checkbox"/> Sensitive skin</p> <p><input type="checkbox"/> Eczema</p>
<p>General Health</p> <p>-Would you say your child's health is?</p> <p><input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>-Has your doctor or health care provider ever told you that your child had any of the following?</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Learning disability</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> ADHD</p> <p><input type="checkbox"/> Congenital heart disease</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Bleeding disorder</p> <p>Other: _____</p> <p>-Is your child currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, which medication(s)? _____</p> <p>-Has your child's behavior ever been assessed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, does your child have: <input type="checkbox"/> IEP <input type="checkbox"/> 504 <input type="checkbox"/> Behavior Plan <input type="checkbox"/> IHP</p>	<p>Allergies</p> <p><input type="checkbox"/> Medication, if yes: _____</p> <p><input type="checkbox"/> Food, if yes: _____</p> <p><input type="checkbox"/> Animals, if yes: _____</p> <p><input type="checkbox"/> Dyes or soaps, if yes: _____</p> <p><input type="checkbox"/> Seasonal, if yes: _____</p> <p><input type="checkbox"/> Bug bites, if yes: _____</p> <p>Gastrointestinal & Urinary</p> <p><input type="checkbox"/> Poor appetite / picky eater</p> <p><input type="checkbox"/> Frequent stomachaches</p> <p><input type="checkbox"/> Diarrhea, how often _____</p> <p><input type="checkbox"/> Constipation, how often _____</p> <p><input type="checkbox"/> Problem with kidneys</p> <p><input type="checkbox"/> Urinary incontinence (wets him or herself)</p> <p><input type="checkbox"/> Fecal incontinence (soils him or herself)</p> <p>Other Problems & Illnesses</p> <p><input type="checkbox"/> Chicken pox - if yes, date of illness: _____</p> <p><input type="checkbox"/> Broken bones - if yes, please specify: _____</p> <p><input type="checkbox"/> Surgery - if yes, provide name and date: _____</p> <p><input type="checkbox"/> Overnight hospitalization – if yes, why? _____</p> <p><input type="checkbox"/> Elevated lead levels - if yes, when? _____</p>
<p>Parent Signature: _____ Date: _____</p> <p>Nurse Signature: _____ Date: _____</p>	

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PERMISSION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of the information listed below between the staff of the Manchester Health Department and:

Provider/Organization Name: _____ Phone: _____

Provider Address: _____ Fax: _____

Information to be exchanged (circle all that apply):

Medical conditions Immunizations Physical Exam(s) TB lab Results

Lead Results Hemoglobin/Hematocrit results

Other: _____

Name of Student **Date of Birth**

Address

I consent to the release of the above information. I further authorize the Manchester Health Department staff to share any health information (including diagnosis and treatment) pertinent to the above student's progress with health care providers and/or school personnel to which I or my child may be referred. I understand this release may be revoked at any time with a written request to the above provider. I understand I may request a copy of this signed release.

I completed this form because I am: *(Please circle one)*

Parent

Legal Guardian

Student over 18 years of age

Signature of Student/Legal Guardian/Parent Date

This authorization is in effect for current year: _____

Please send records to: _____

Attention: _____